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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

DR. NATHANIAL F. WILLIAMS,
Petitioner,

v.

VISION CARE SERVICES, INC.,
Respondent.

BRIEF OF VISION CARE SERVICES, INC. IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA

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QUESTIONS PRESENTED

1. Consistent with Section 1 of the Sherman Act, may an insurer under a contractual obligation to provide services to specified beneficiaries enter into bilateral contracts with individual doctors specifying the fees which it will pay for services rendered to the beneficiaries?

2. When an insurer is contractually required to provide ophthalmic materials to its beneficiaries and where the insurer contractually agrees to reimburse the doctor for the cost of materials dispensed, may the insurer, which has no financial interest in any supplier, require that the doctor obtain the ophthalmic materials from suppliers who agree to maintain certain quality standards?

TABLE OF CONTENTS

	PAGE
QUESTION PRESENTED	i
STATEMENT OF THE CASE	1
SUMMARY OF REASONS FOR DENYING THE PETITION	5
ARGUMENT:	
I. Consistent With Section 1 Of The Sherman Act, An Insurer Under A Contractual Obligation To Provide Services To Specified Beneficiaries May Enter Into Bilateral Contracts With Individual Doctors Specifying The Fees Which The Insurer Will Pay For Services Rendered To The Beneficiaries	6
II. Where An Insurer Is Contractually Required To Provide Ophthalmic Materials To Its Beneficiaries And Where The Insurer Contractually Agrees To Reimburse The Doctor For The Cost Of The Materials To Be Dispensed, The Insurer, Which Has No Financial Interest In Any Laboratory, May Require That The Doctor Obtain The Ophthalmic Materials From Suppliers Who Agree To Maintain Certain Quality Standards	9
CONCLUSION	11

TABLE OF CITATIONS

Cases

Advance Systems and Supply Co. v. SCM Corp., 415 F.2d 55 (4th Cir. 1969), *cert. den.* 397 U.S. 920 (1970)	10

	PAGE
Arizona v. Maricopa County Medical Society, ___ U.S. ___, 50 U.S.L.W. 4687 (1982)	8
Blue Cross & Blue Shield v. Michigan Ass'n. of Psychotherapy Clinics, 1980-2 Trade Cases ¶63,351 (E.D. Mich. 1980)	9
Elliott & Frantz, Inc. v. Raygo, Inc., 379 F. Supp. 498 (E.D. Pa. 1974)	10
Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979)	7
Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc., 675 F.2d 502 (2nd Cir. 1982)	8
Pitchford v. Pepi, Inc., 531 F.2d 93 (3rd Cir. 1975), *cert. den.* 426 U.S. 935 (1976)	10
Quality Auto Body, Inc. v. Allstate Insurance Company, 660 F.2d 1195 (7th Cir. 1981), *cert. den.* ___ U.S. ___, 72 L. Ed. 2d 138 (1982)	8
Sausalito Pharmacy, Inc. v. Blue Shield of California, Inc., 677 F.2d 47 (9th Cir.), *cert. den.* ___ U.S. ___, 43 ATRR 929 (1982)	8
Traveler's Ins. Co. v. Blue Cross of Western Pennsylvania, 481 F.2d 80 (3rd Cir.), *cert. den.* 414 U.S. 1093 (1973)	9
Webster County Memorial Hospital v. United Mine Workers of America Welfare and Retirement Fund of 1950, 536 F.2d 419 (D.C. Cir. 1976)	8-9

Statutes

15 U.S.C. § 1	6
15 U.S.C. § 14	6, 9-10
15 U.S.C. § 1012(b)	7

PAGE

Rules of Court

F.R. Civ. P. 54(b) 4-5

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STATEMENT OF THE CASE

The petition for a writ of certiorari filed by Dr. Nathanial F. Williams does not accurately set forth the vision care plan at issue. Therefore Vision Care Services, Inc. ("VCS") must do so.

The vision care plan at issue is a pre-paid group plan using a panel of doctors who are free to deal with any of the many laboratories who have agreed to meet specified quality standards.

A group is simply any public or private entity that desires to provide vision care benefits to designated beneficiaries. (AA 36, 87-88).[1] The group then enters into a contract ("the insurance plan" or "plan") with VCS whereby it obtains the desired services and materials. VCS is a not for profit member corporation duly qualified as a non-profit insurer under the laws of Maryland. (AA 39).

The benefits purchased by the group for its beneficiaries generally include an annual eye examination and prescription glasses, provided that the glasses are medically required and provided that their laboratory cost does not exceed a stated allowance. If the cost does exceed the allowance, then VCS agrees to provide the eyeglasses to the beneficiary at a price equal to the difference between the allowance and the laboratory cost.[2] (AA 36).

Optical services are actually performed by licensed optometrists and ophthalmologists ("panel doctors") who enter into contracts with VCS ("participating doctor's contract"). The participating doctor's contract does not obligate VCS to provide any panel doctor with patients, but simply obligates VCS to publish a list of panel doctors which is disseminated among the beneficiaries who decide which doctor to use. The participating doctor's contract also requries VCS to pay the panel doctor for examinations actually performed on the basis of the lesser of his usual and customary fees or an allowance established for each plan. (AA 37, 85, 94-95).

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[1] "AA" and "SA" respectively refer to the appendix and the supplementary appendix filed in the court below.

[2] The plans may also provide for other benefits. For example, if a beneficiary desires to purchase ophthalmic materials for which no reimbursement or allowance is available (i.e., a second pair of glasses), then VCS agrees to provide those ophthalmic materials to the beneficiary at a price equal to the laboratory cost plus a dispensing fee. (AA 36-37, 39).

If the doctor dispenses ophthalmic materials to the beneficiary, then VCS must pay the doctor an additional dispensing fee and reimburse him for the cost of the materials. Unless prior authorization is obtained, materials dispensed under the program must come from a laboratory approved by VCS. The approval procedure is designed to insure that the participating laboratories, *in which VCS has no financial interest*, are full service laboratories producing frames and lenses of a specified quality. (AA 37-38, 88-90). Quality materials are important to VCS because of the marketing emphasis placed on the high quality of services and materials it offers. (AA 38).

With this background in mind, the relationship between Dr. Williams and VCS can be examined. Dr. Williams was a panel doctor from 1972 until early 1977. (AA 3). During his tenure beneficiaries occasionally requested him to dispense ophthalmic materials for which no reimbursement was available from VCS. When dispensing these supplementary materials, Dr. Williams charged the beneficiary at rates which he determined. (SA 100, 132-137).

In 1976 Dr. Williams requested payment for services and materials allegedly provided to a beneficiary named Irving Rich. Payment, however, was refused because the plan administrator noted that the payment form, completed and signed by Dr. Williams, stated that the examination had taken place after Mr. Rich had died. (AA 100, SA 18, 108).

The plan administrator forwarded this information to VCS which directed its internal peer review committee to investigate. (AA 100-102). After this investigation and after Dr. Williams had responded at an evidentiary hearing, the peer review committee concluded that Dr. Williams had no satisfactory explanation as to how he had

examined and dispensed materials to a deceased beneficiary. Moreover, the investigation and hearing revealed that Dr. Williams (a) kept virtually no medical records on his VCS patients; (b) on at least one occasion dispensed to a beneficiary single vision lenses, but sought reimbursement from VCS for more expensive bifocal lenses; and (c) continually dispensed to VCS patients materials from an unapproved laboratory even though he was fully satisfied with the quality of the work performed by the approved laboratories. (SA 80, 118-119, 139-140). Subsequently, Dr. Williams was terminated as a panel doctor. (AA 102, SA 147).

Discovery in this case has substantiated these findings. For example, Dr. Williams' medical records on VCS patients typically did not include such basic information as the patient's age, occupation, complaint regarding vision, nature or results of any tests performed, previous prescription, acuity without glasses, acuity under an existing prescription, or acuity under any new prescription. (SA 68-98). Dr. Williams conceded that good medical practices as well as his participating doctor's contract required him to keep such records. (SA 67-69, 73).

Dr. Williams also conceded that during the year immediately prior to his termination he was using unapproved laboratories to provide ophthalmic materials to at least 75% of his VCS patients. (SA 28-29). This was not done out of any dissatisfaction with the quality of materials or service received from approved laboratories nor out of any unwillingness of the approved laboratories to ship materials to Dr. Williams. (SA 26-28). Precisely why Dr. Williams chose to use the unapproved laboratories remains to be litigated.[3] The unapproved laboratory

[3] In its counterclaim VCS asserted that Dr. Williams' fabrication of these invoices was simply an artifice to obtain money fraudulently from VCS by seeking reimbursement from VCS for an amount greater than the actual laboratory costs that VCS

used by Dr. Williams never applied for approved status even though such status was routinely granted laboratories meeting certain industry quality standards and Dr. Williams requested that the laboratory make such an application. (AS 90, SA 78-79).

Upon the completion of discovery, VCS filed its motion for summary judgment which pursuant to the local rules of the District of Columbia included a separate pleading outlining the material facts which were not in dispute. (AA 39-42). Although Dr. Williams was granted several extensions of time within which to file a response, no formal response ever appeared on the trial court's docket. (AA 1-3). While he was proceeding *pro se*, Dr. Williams did deliver to the chambers of the trial judge a document setting forth his position with respect to the motion. Although this document (AA 44-47) was apparently not filed with the clerk of the trial court, the trial judge did consider it and heard argument from Dr. Williams' present attorney at a hearing on the motion for summary judgment. Finding no dispute as to any material fact and finding VCS was entitled to judgment as a matter of law, the trial court granted the motion and was subsequently upheld by the Court of Appeals.

SUMMARY OF REASONS FOR DENYING THE PETITION

The writ of certiorari is a vehicle by which this Court has decided those questions of law about which the federal courts are in disagreement or even when in agreement have overlooked some fundamental precept of law. Measured against those standards, the petition should be denied.

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promised to pay any panel doctor. Because his appeal was prosecuted pursuant to a F.R. Civ. P. 54(b) certification, the counterclaim has not been adjudicated.

In recent decisions, this Court has considered and defined when insurance companies are engaged in the business of insurance and are thereby exempt from the antitrust laws. Left to the lower courts, however, has been the question of whether the antitrust laws are violated by any particular bilateral contract between an insurer and a supplier of services or materials. In considering the questions left to them by this Court the lower courts have universally held that contracts such as those at issue violate neither § 1 of the Sherman Act nor § 3 of the Clayton Act.

It is not the decisions of these lower courts, but the petitioner's position in this litigation which overlooks a fundamental precept of the antitrust laws. A contractual agreement between a buyer and a seller fixing the price to be paid by the buyer does not come within the scope of the prohibition against price fixing even where the buyer is not the beneficiary.

ARGUMENT

I.

CONSISTENT WITH SECTION 1 OF THE SHERMAN ACT, AN INSURER UNDER A CONTRACTUAL OBLIGATION TO PROVIDE SERVICES TO SPECIFIED BENEFICIARIES MAY ENTER INTO BILATERAL CONTRACTS WITH INDIVIDUAL DOCTORS SPECIFYING THE FEES WHICH THE INSURER WILL PAY FOR SERVICES RENDERED TO THE BENEFICIARIES.

The insurance plan basically provides that in return for a specified premium paid by the group, VCS will provide certain ophthalmic services to the beneficiary without charge or cost to that beneficiary. This plan differs from the typical health insurance policy only in that the insurer instead of agreeing to pay for required ophthalmic services simply agrees to provide the services. By executing a participating doctor's contract, a panel doctor such as Dr.

Williams agrees to provide those services in return for a specified payment from VCS.[4] Contrary to Dr. Williams' suggestion, neither this Court nor any other court has held that the antitrust laws are violated by such a bilateral agreement between a provider of services and an insurer obligated to provide beneficiaries with those services.

Two recent decisions of this Court, however, have referred to the question without deciding it. In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), the precise question at issue was whether an agreement between an insurer and a pharmacy implementing prescription drug benefits for the insurer's policy holders was exempt from the antitrust laws as the business of insurance under the McCarren-Ferguson Act (15 U.S.C. § 1012(b)). The defendant offered insurance policies which entitled beneficiaries to obtain prescription drugs. If the pharmacy used by the beneficiary had executed a pharmacy agreement with the insurer, the beneficiary was required to pay only two dollars for every prescription drug with the remainder being paid directly by the insurer to the participating pharmacy. This Court was careful to note that, "Whether the agreements are *illegal* under the antitrust laws is an entirely separate question, not now before us." *Id.* at 210, n.5 (Emphasis in the original). It was also noted by this Court that the United States in its amicus brief took the position that the agreements "probably do not violate the antitrust laws." *Id.*

[4] In his petition Dr. Williams asserts that because 20% of all doctors' fees are withheld by VCS to fund possible shortfalls in any plan, the doctors rather than VCS bear the ultimate economic risk of any insurance plan. While the doctors may share in this risk, it is VCS which bears the unlimited and ultimate risk of this insurance plan.

In *Arizona v. Maricopa County Medical Society*, ___ U.S. ___, 50 U.S.L.W. 4687 (1982), this Court considered the question of whether it was illegal for two medical societies to establish fee schedules that their member doctors would accept as full payment for health services provided to policy holders of specified insurance plans. Significantly, the defendant medical societies were not insurers under an obligation to pay the doctor for services rendered to policy holders. In a four to three decision this Court held that the foundations were engaging in maximum price fixing, but again carefully circumscribed the scope of its decision.

> "Nor does this case present the question whether an insurer may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors. That question was not reached in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) *See, Id.* at 210, n.5. In an *amicus curiae* brief, the Department of Justice expressed its opinion that such an arrangement would be legal unless the plaintiffs could establish that a conspiracy among providers was at work . . . Our point is simply that the record provides no factual basis for the [medical society's] claim that the doctors must fix the fee schedule." *Id.* at _____, n.26, 50 U.S.L.W. at 4692, n.26.

While this Court has not directly ruled on the question at hand, numerous lower courts have reached that conclusion that such bilateral agreements between an insurer and a provider do not run afoul of the antitrust laws even where the beneficiary is obligated to pay a portion of the purchase price to the provider. *See, e.g., Sausalito Pharmacy, Inc. v. Blue Shield of California, Inc.*, 677 F.2d 47 (9th Cir.), *cer. den.* ___ U.S. ___, 43 ATRR 929 (1982); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502 (2nd Cir. 1982); *Quality Auto Body, Inc. v. Allstate Insurance Company*, 660 F.2d 1195 (7th Cir. 1981), *cert. den.* _____ U.S. ____, 72 L. Ed. 2d 138 (1982); *Webster County Memorial Hospital v.*

United Mine Workers of America Welfare and Retirement Fund of 1950, 536 F.2d 419 (D.C. Cir. 1976); *Blue Cross & Blue Shield v. Michigan Ass'n. of Psychotherapy Clinics*, 1980-2 Trade Cases ¶63,351 (E.D. Mich. 1980). Indeed, even where the insurer possessed considerable market power as evidenced by its providing hospitalization insurance for 51% of the population in the market area and by its accounting for 62% of all patient days covered by commercial insurance, bilateral arrangements between the insurer and the provider specifying the fee to be paid have been upheld. *Traveler's Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F 2d 80 (3rd Cir.), *cert. den.* 414 U.S. 1093 (1973).

Thus, the holding of the trial court and the United States Court of Appeals for the District of Columbia that this bilateral arrangement between VCS and its panel doctors does not violate the antitrust laws is fully supported by the applicable case law. Indeed, given that this insurance plan obligates the insurer to provide services and materials rather than simply paying for the cost of those services and materials, there is even greater reason for holding that the bilateral contracts between VCS and panel doctors do not violate the antitrust laws.

II.

WHERE AN INSURER IS CONTRACTUALLY REQUIRED TO PROVIDE OPHTHALMIC MATERIALS TO ITS BENEFICIARIES AND WHERE THE INSURER CONTRACTUALLY AGREES TO REIMBURSE THE DOCTOR FOR THE COST OF THE MATERIALS TO BE DISPENSED, THE INSURER, WHICH HAS NO FINANCIAL INTEREST IN ANY LABORATORY, MAY REQUIRE THAT THE DOCTOR OBTAIN THE OPHTHALMIC MATERIALS FROM SUPPLIERS WHO AGREE TO MAINTAIN CERTAIN QUALITY STANDARDS.

Whether VCS, which has no laboratories nor any financial interest in any laboratory, may justifiably require ophthalmic goods purchased for its account be from designated sources of supply without violating § 3 of the

Clayton Act (15 U.S.C. § 14) is an issue which has long been settled. In his attempt to show otherwise, Dr. Williams simply failed to prove any of the elements of a violation of § 3 of the Clayton Act.

The first element in a Clayton § 3 case is that the contract at issue be one involving a lease or sale of goods as opposed to the purchase of services. *See, e.g., Advance Systems and Supply Co. v. SCM Corp.*, 415 F.2d 55 (4th Cir. 1969), *cert. den.* 397 U.S. 920 (1970). The contract between Dr. Williams and VCS, however, is simply one whereby VCS purchases services from Dr. Williams. While Dr. Williams may purchase materials for VCS's account, he does not sell any goods to VCS.

In a Clayton § 3 case it is also incumbent upon the plaintiff to prove that the sale at issue is one whereby the seller through the vehicle of an exclusive dealing arrangement is attempting to preclude the buyer from buying or leasing the goods of its competitor. The seller and the precluded supplier must be competitors. *See, e.g., Elliott & Frantz, Inc. v. Raygo, Inc.*, 379 F. Supp. 498 (E.D. Pa. 1974). In this case the allegedly precluded suppliers, the non-approved laboratories, are not competitors of VCS because VCS neither owns a laboratory nor does it have any financial interest in any laboratory.

Finally, in a Clayton § 3 case it is necessary for the plaintiff to prove that that the effect of the agreement is either to "substantially lessen competition or tend to create a monopoly in any line of commerce." *See, e.g., Pitchford v. Pepi, Inc.*, 531 F.2d 93 (3rd Cir. 1975). *cert. den.* 426 U.S. 935 (1976). Dr. Williams did not produce any economic data suggesting how competition was affected by the alleged exclusive dealing arrangement nor did he produce any proof that any competitor was actually precluded from selling its goods to VCS. The evidence affirmatively demonstrates that the opportunities for any

laboratory to enter the program are not limited because any laboratory desiring to sell goods to VCS simply has to make an application to VCS so that it may determine that quality standards will be upheld. There is no evidence that the quality standards were arbitrarily applied, but instead all of the evidence simply demonstrates that many laboratories could and did meet the approved quality standards. It is, of course, unknown whether the unapproved laboratory which Dr. Williams chose to use did meet these specified quality standards for the simple reason that that laboratory chose not to make an application.

CONCLUSION

No compelling reason exists for this Court to exercise its jurisdiction by granting petitioner's writ of certiorari. There is no conflict among the circuits on this issue and the factual record before this Court discloses no reason why this particular bilateral agreement between an insurer and a supplier of services violates the antitrust laws.

Respectfully submitted,

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